Outreach, Enrollment, and Recertification
in the DC Medicaid and DC HealthCare Alliance Programs

Background Information for the State Planning Grant (SPG) Health Coverage Advisory Panel

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With excerpts from focus groups compiled by Heather Sacks

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At the January 10, 2005 meeting of the SPG Health Coverage Advisory Panel, members spoke of opportunities to extend health coverage to District residents by maximizing enrollment in existing public programs. It was decided that issues of outreach, enrollment, and recertification in DC Medicaid and the DC HealthCare Alliance merited further discussion and possible action in the form of recommendations. In preparation for the February meeting where these issues will be the focus, interviews of Panel members and other experts were conducted by telephone February 4 – 14, 2005. The purpose of the interviews was to document the successes, shortcomings, and proposed improvements related to enrolling eligible persons in Medicaid and the Alliance. The following persons were interviewed (* indicates a Panel member):

Government Officials

Brian Haile*, Income Maintenance Administration
Kate Jesberg*, Income Maintenance Administration
Martha Knisley*, Department of Mental Health
Rob Maruca*, Medical Assistance Administration
Desmond Yorke, DC HealthCare Alliance, Health Care Safety Net Administration

Providers

Sharon Baskerville*, DC Primary Care Association
Tamara Smith, Chartered Health Plan
Debi Tucker*, DC Hospital Association
Henry Williams*, Medical Society of DC/Howard University
Case managers (2), local community health center

Advocates

Eugenio Arene*, Council of Latino Agencies
Larry DeNeal*, United Planning Organization
Sam Jordan*, Health Care Now
Leighton Ku, Center on Budget and Policy Priorities
Cheryl Fish Parcham, Families USA
Sarah Spector, DC Legal Aid

In the table that follows, information provided by interviewees is organized into six major categories. Comments on each of these topics are divided into three groups: success/improvement, areas for change, and recommendations. Comments are attributed to one of the groups above rather than to individuals. One of the most discussed topics--developing a common enrollment process for programs—is discussed separately at the end of the table.

Findings from interviews

Topic	Success/Improvement	Areas for Change	Recommendations
Outreach *Summary:* Outreach efforts are expansive and multi-faceted. However, the most cost-effective outreach likely occurs when community organizations educate their clients about the programs and help them enroll.	<u>Outreach efforts</u> 1. Presentations at community meetings, churches, ESL classes. 2. DC Healthy Families forms at CVS, Giant, and Safeway. 3. Bus ads, radio. 4. At least one Medicaid HMO sends enrollment worker to clinic sites on a regular basis. 5. Enrollment broker funded by MAA uses health fairs, community events, and churches for outreach. Health Pact, connected with the DC Medical Society, also holds health fairs, where people can learn about the programs. 5. IMA's web site has information on programs to educate social services agencies. <u>Positive feedback about outreach efforts</u> 1. DC Healthy Families has done very well in its outreach efforts (1 advocate, 1 provider) 2. IMA in general is doing a good job (has received national recognition for its high enrollment rates; enrollment has been rising at about 4% per year (2 government, 1 provider) 3. Alliance has experienced growth in enrollment from 6,000 in 2001 to a high of 24,000. (1 government) 4. Word of mouth—via friends and family—or from one's primary care provider or other trusted community organization is most effective, especially in light of low literacy rates. Even if materials are translated into different languages, the inability to read will make this form of outreach ineffective. Nonetheless, for patients who can read, having translated materials is important. (2 providers) 5. Persons are often most receptive to learning about the programs when they are sick and in need of services; thus, providers play an important role. (1 provider) 6. Materials are linguistically and culturally appropriate (1 advocate). MAA materials are in Spanish and English with a statement in many languages informing the reader of the phone number to call for translation (1 government).	<u>Lack of clarity/need for education</u> 1. Because of the variety of programs (Medicaid HMOs and fee-for-service, Alliance, etc.), confusion exists among eligibles and social services community. (2 advocates) 2. Information for social services agencies on the Home and Community-Based Care waiver and Medicaid for the elderly is especially lacking. (1 advocate) 3. People need to be educated more about their rights under the programs. (2 advocates) <u>Outreach methods</u> 1. Alliance does not seem to do as much outreach as Medicaid. (1 provider) (Alliance said they have decreased publicity/marketing since start of program and rely more on community-based partners—namely, the providers--for outreach.) 2. Bus and radio ads are expensive and not as effective as person-to-person outreach in the community (2 providers, 1 government). 3. Private doctors' offices do not have the resources to help with outreach; more support is given to clinics. <u>Immigrants</u> 1. More could be done to reach the non-English speaking population. (1 advocate)	<u>Lack of clarity</u> Coordinate outreach materials among Medicaid, Alliance, and mental health programs. (1 provider) <u>Outreach methods</u> 1. Given the importance of community-based organizations in educating persons about the programs, more effort should be made to partner with and support these entities, including training and providing them with up-to-date information about the programs. (3 providers, 1 advocate, 1 government) Note: Hospitals seem not to automatically provide social work assistance to patient. Patient or their advocate has to request social work help to learn about and enroll in a health program. (1 advocate) 2. Place brochures at metro stations and shopping centers (1 advocate). 3. Go into the community more—door-to-door, basketball games, community meetings. Need outreach workers who are not just 9-5. (1 advocate) <u>Immigrants</u> 1. Specific outreach to service (hotel, janitorial companies) and construction employees. (1 provider)

Related findings from SPG focus groups

Some of the mechanisms used to conduct outreach:

"I saw it on TV, or the radio and newspapers."

"I talked to other people and with the social worker and she told me that I could apply for Alliance."

Some focus group participants were not aware of any of the programs offered:

"They don't give you information – where to go and get insurance, in the clinics or the community."

"I think the problem is accessibility. Public relations and such. I'm asking myself, why don't I have more information about the DC Alliance?"

Some outreach may also be geared toward changing negative perceptions of the program:

"DC Alliance does not have a good reputation. They're out there; they're not reliable. As much as I've heard the elected officials say what a success this is, it's a lie."

Additional suggestions include:

"I wanted to say . . . on cable TV, like Comcast or Cable 16, they have like free infomercials."

"Evidently you don't visit your community centers and you don't go to the forums and so on because they have this." *In response to how the District can have more PR about the kinds of things that are available*

"I think the simplest way to inform me is if I got it in the mail from the city, a brochure that said DC Alliance. Information about DC Alliance and it explained to me what it was, what it offered."

Findings from interviews

Topic	Success/Improvement	Areas for Change	Recommendations
Forms: Enrollment & Recertification *Summary:* Forms, including one in development, are user friendly, with perhaps the exception of the Medicaid recertification form.	1. Forms are fairly simple, but social workers still must complete for most clients due to low literacy (1 provider) 2. DC Healthy Families' form is especially user friendly, "wonderful." (1 advocate, 1 provider) 3. Alliance form has improved, is "easy" (shortened from 4 to 2 pages). (1 advocate, 1 provider, 1 government) 4. Combined form for Medicaid, Food Stamps, and TANF has been drafted, reducing the number of pages to 6 and reading level to 5th grade. Requires DC Council and CMS approval.	1. 15-page combined application for Medicaid, Food Stamps, and TANF is challenging. (1 advocate, 1 provider) 2. Some questions on the Alliance form are offensive ("How long have you been homeless?" "Do you receive other benefits?") (1 advocate) 3. Medicaid recertification form is hard to complete—4 pages of tiny font—and is especially hard for seniors. (2 advocates) IMA has said it is expensive to change. (1 advocate) [IMA explains that the 4 pages are envelope size and much of the information is already pre-printed on the form. The same form is used for managed care and fee-for-service Medicaid.]	1. Technical assistance hotline staffed by DHS to assist applicants in completing applications. (1 advocate)

Related findings from SPG focus groups

The general consensus was that the application form itself was rather straightforward:

"It was easy to fill out the paperwork"

"DC Healthcare Alliance, it's pretty easy to enroll. Except if they lost information, you have to go through the process all over again."

"I applied with TANF to be enrolled in Medicaid. It was basically done through the office, so I didn't have to fill out any papers. So that was really easy."

"The most positive thing for me is that I don't have to go personally to re-apply for Medicaid. I can just do that through the mail. I like that a lot."

Findings from interviews

Topic	Success/Improvement	Areas for Change	Recommendations
Documentation: Enrollment & Recertification *Summary:* Medicaid documentation is more flexible than that of Alliance. Although some stringency is reasonable to protect program integrity, loosening the requirements of the Alliance to match those of Medicaid would be well received by providers and patient advocates.	1. Medicaid is more flexible with documentation. For example, it will accept a phone bill as proof of residence. (Alliance will not because it is possible to obtain a DC-addressed bill without being a DC resident). (1 provider, 1 advocate) 2. Medicaid will accept a handwritten letter from a family member or friend attesting to the person's residence in their home. (1 advocate, 1 provider) 3. Documentation for the combined Medicaid/Food Stamps/TANF application will be standardized under the changes proposed by IMA (see "Forms" section above). (1 government) 4. Medicaid enrollees have access to a drop-off box when IMA sites are closed, or they may fax documentation. A new telephone system allows clients to update certain information, such as a new address, by leaving a message. (1 government) 5. Alliance only requires a letter from a shelter to prove a homeless person's residence in DC. (1 government, 1 provider) 6. Some hospitals have improved enrollment of patients by contracting with a private firm that assists patients in gathering the required documentation. (1 provider, 1 government)	1. Alliance has made obtaining proof of DC residence and income more difficult. Applicants need a DC ID card from DMV or their name on a utility bill or lease. For people who "double up" and pay their rent in cash, the latter is difficult to obtain. For an applicant without a Social Security number, the person with whom they live may complete a form verifying the applicant's DC residency and attach the required proof. Applicants who have a Social Security number cannot use this form. Rather, they must obtain a DC ID card, which involves bringing the person with whom they live to the DMV to verify their address. (1 provider) 2. It is difficult for the homeless who are not connected to a shelter to present necessary documentation. (1 advocate, 1 provider) 3. Proof of income may be rejected if applicant does not have pay stubs. Although a letter from an employer is allowed in some cases, it is rejected in others. (1 provider) Note: It is assumed that Alliance has become more stringent due to an audit revealing numerous non-DC enrollees and because of budget overruns (1 government, 1 provider) 4. Although difficult, the Alliance requirements can be met with some effort and represent a balance between program integrity and ease of access. (3 providers) Enrollment levels have been fairly stable in recent months, which could indicate that people are able to meet the requirements for enrollment and re-enrollment (1 provider). Other opinion: Greater stringency on residency requirement is not a problem for most Alliance eligibles but is preventing certain people from enrolling in the Alliance, especially immigrants. (1 advocate) 5. Alliance makes changes to documentation requirements, and community-based organizations and providers are not informed adequately. Sometimes application denials seem random. (1 advocate, 1 provider) 6. People are confused about Alliance's documentation requirements and have to make more than one trip to complete application; this is challenging when public transportation is involved. (1 advocate)	1. Make Alliance requirements for proof of residence similar to Medicaid. (1 advocate) 2. Clarify in promotional materials the documentation requirements. (1 advocate)

Related findings from SPG focus groups

While the actual application form was perceived to be easy to fill out, participants did not feel that the paper requirements were straightforward:

"A lot of paper work, too many papers."

"They ask you for all these documents and then they only give it to you for thirty days."

"I got there and gave her all the papers, my identification from Washington, DC, my telephone number, my address, everything. And she said to me, 'I need you to bring me a letter from the landlord, the owner of the house and a DC ID or I can't help you.' And after having been there for four hours!"

"I'm not against giving that information, but the owner of the house is against it, he says that he can't give me any of that. So, what does that mean? That because you as an owner can't give me that, I can't get insurance?"

"You have to have your phone number in your name, at the same place where you live, and it can't be a cell phone."

"If only they gave you a list of the papers you need to bring . . . I think it's very complicated."

"I had one in 2002 – it was Alliance. I had it only for six months and it ran out – and I had many problems trying to renew it. I couldn't get any again because I quit my job, I have a child, and they ask me for checks stubs, ID. They also asked me for proof of residence – a driver's license. I couldn't renew it because they asked me for so many papers."

Findings from interviews

Topic	Success/Improvement	Areas for Change	Recommendations
Enrollment Process (General) *Summary:* The process of enrolling people, separate from the issues of forms and documentation, is relatively smooth, more so for Medicaid but improving for Alliance.	1. DC Council recently approved establishment of a Health Insurance Ombudsman to assist DC residents with problems they encounter trying to obtain coverage; it has not been funded yet. (2 advocates) <u>Medicaid</u> 1. DC Healthy Families has done a "great" job enrolling people. Application can be mailed rather than requiring a face-to-face interview. (1 advocate, 1 provider) Medicaid, in general, is doing well with enrollment, based on the increases in enrollees. (1 provider) 2. Medicaid enrollment is a smooth process; it typically takes two weeks to obtain a number but it can be retroactive for 90 days of services. (1 provider) 3. Medicaid makes more of an effort to enroll people and offer assistance in the process relative to Alliance. (1 provider) 4. Hospitals are pleased with the IMA "roving supervisor" who reviews and can approve Medicaid applications on the spot. (1 provider) 5. IMA now has evening hours at most of its seven sites and an on-line application. Providers may now track the enrollment process of patients via the Internet. (1 government) 6. Although IMA has 45 days to determine eligibility, the median application time is 12 days. IMA can process an application in one day in emergency situations. (2 government) <u>Alliance</u> 1. An Alliance secondary site, which can complete applications but not confer eligibility, appreciates the recently instituted weekly visit by an Alliance enrollment worker to process forms on site and assign a number. In other ways, as well, it seems the Alliance is working with them rather than against them, which is an improvement from the recent past. (1 provider) 2. Alliance has reduced the number of presumptive eligibles (those who are granted 30 days of eligibility despite incomplete documentation) from 5,000 to about 1,000 at any given time. (1 government) 3. Alliance's enrollment turnaround is quicker than that of Medicaid. (1 provider)	<u>Alliance</u> 1. Alliance creates more hurdles relative to Medicaid (perhaps due to wanting to limit enrollment?). (1 provider) In general, there seem to be more problems with enrollment in Alliance compared with Medicaid. (1 government)	1. The ombudsman should be funded. (2 advocates)

Related findings from SPG focus groups

There are mixed opinions on the ease of enrolling:

"I just recently learned that I have diabetes and I went to the Southeast Community for a second opinion and I had no insurance. That's when I learned about DC Healthcare Alliance and was enrolled. And I found it a pretty easy process. It has been wonderful for me ever since."

"You can go right to a hospital office and ask them if they have DC Alliance or Chartered Health, anyone of those insurance, you can take your application and fill it out right there."

"[Y]ou're sitting in a dumpy waiting room and treated like a piece of garbage and have to wait five or six hours and you have to stand and so it's like, why aren't people clamoring to sign up for the Alliance?"

Findings from interviews

Topic	Success/Improvement	Areas for Change	Recommendations
Recertification Process (General) *Summary:* Recertification is more problematic than initial enrollment because clients do not receive notices or do not act on the notices they do receive. With access to the necessary information, providers can play a role in notifying clients of their impending expiration date.	Medicaid 1. Medicaid does well with sending out recertification notices, although some clients may throw the notice away because they are unaware of the contents. Form is simple and only proof of income is required. (1 provider) 2. Medicaid mails two reminders after the first notice is sent. Clients have 90 days to recertify. (1 government) Alliance 1. Alliance's expansion of the enrollment period to one year is a big improvement. (1 advocate)	1. Alliance and Medicaid recertification and other notices are written in English only. (1 advocate's impression—does not speak with certainty) Medicaid 1. Communication from Medicaid about the reasons for denying an application is not adequate. (1 advocate) Alliance 1. Alliance is not sending out recertification notices (1 advocate, 1 government, 1 provider) [Alliance says it sends out notices 30 days prior to expiration, though it is difficult due to the transience of enrollees.]	1. Alliance should send out notices to recertify. (2 advocates, 2 providers, 1 government) 2. Fee-for-service Medicaid enrollees should be assigned case managers not only to manage their care but also to assist with re-certification. (1 advocate) 3. Providers should take more initiative to remind patients of expiration date (1 advocate, 2 providers). To assist providers, Medicaid should add to its automated eligibility line an expiration date. Alliance should institute an automated eligibility line. (2 providers)

Related findings from SPG focus groups

The primary complaint with the recertification process was that it was too frequent:

"When I first got it, it was terrific. Once you're with it, after a year, umph! You have to fill out applications all over again to get Medicaid. For 30 days. You have to go through it all over again."

"I've had it before and it seemed to be the six months that they tell you that you can have it for six months and then you have to go back and re-up. [B]y the time they send you the card to do what you have to do, the six months is gone so you have to re-up again . . .you go through all this red tape of signing up again . . ."

Others have complaints that they were unaware their insurance ran out:

"It ran out and they never told him, when they alerted him, it had run out already."

"My insurance expired, then I said that I wanted to renew it, they told me, there is no renewal, you have to do all the steps like new, but now you have to add another piece of paperwork we are adding."

"On two occasions, I've scheduled to go in so I could go to the intake office to re-certify, and when I show up at Walker Jones, at their intake office, there is no staff there."

"I know a lot of times they come when its time for you to re-certify . . . they will generally come out and knock on our door, or leave a doorknocker hanging on your door just to let you know."

Findings from interviews

Topic	Success/Improvement	Areas for Change	Recommendations
Enrollment Staff ***Summary:*** Despite concerted efforts by IMA to improve customer service at its community sites, complaints about enrollment staff continue.	Medicaid 1. Training of IMA staff, including cultural competency, is extensive and ongoing. IMA recently developed a new policy manual for enrollment staff and has revised the Medicaid curriculum used for training. IMA supervisors are available by phone or email to provide assistance to workers. IMA is attempting to shift the culture so that staff recognize their efforts make a difference in whether a person receives an urgently needed benefit promptly. Improving customer service has received much attention lately and has included terminating some employees who do not perform well. (2 government, 2 providers) Alliance 1. Alliance workers have better customer service skills than IMA staff (1 advocate) 2. Alliance staff attend trainings on completing forms correctly (1 government) 3. Using community-based organizations to enroll people in the Alliance is working well and is a good solution to cultural and language barriers. Many applicants are uncomfortable with formal government agencies. (1 provider)	Medicaid 1. Cultural insensitivity, rudeness, and lack of knowledge of programs are problems found in the IMA enrollment staff. Phone calls are not returned or voice mailboxes are full. It can be hard to change the culture—salaries are low and turnover is high. High turnover is difficult for clients because they are frequently assigned a new caseworker. Even if there are Hispanic caseworkers, not all Hispanics are assigned to them; assignment is by geographic area. (1 advocate) 2. Long waits and lack of interpreters are complaints of clients. (1 provider) 3. Workers do not display enough sensitivity toward clients. (1 provider)	1. Both programs should employ more staff from the immigrant community. (2 advocates) 2. Cultural competency training is necessary. (1 provider)

Related findings from SPG focus groups

Some participants have had positive experiences with enrollment staff:

"I went to Cardozo because a friend of mine used to go there. There was a lady there who was very nice. And I went to DC Alliance and I had the papers. I brought the papers, and even if I didn't bring all my papers, she was very nice and helped me . . . I never had any problem!"

"When they first started having Chartered, they were like coming out, knocking on the doors, talking to you and getting you to switch over . . . yes they do (chase you down to get you to sign up) [T]hey're still out there . . .them (sp.) come knocking on your door all the time."

Others have had negative experiences:

"They just seem to set their own hours."

"They're asking for birth certificates now and the people in charge of the process . . . they are not accessible, they are not very nice."

"I called them and I explain to them that I had gotten the letter late. But their answer was that they had insured another two people instead of us."

The majority of the complaints are because of cultural insensitivity or language problems, sometimes leading to confusion over document requirements:

"Yes, she spoke Spanish. But she asked me, 'how many years of school have you had?' She humiliated me."

"They used to tell me that I did not qualify, and especially because I didn't speak English, they didn't even give you any attention – they didn't care about you. Or they kept sending me back and forth, asking for different documentation or papers all the time."

The language and cultural differences also led to confusion over document requirements

"Nobody spoke Spanish, and applications are very complicated. They ignore you when you need help and they don't listen to you."

"The person that was working here did not speak much Spanish and she said to me, 'No, no no, - you need more documents."

Problems exist with telephone assistance too:

"And you know, sometimes we do get people on the phone who speak Spanish, but they're very nasty – they're in a bad mood."

"They ask you for lots of papers and make you go back and forth for that paper – and its very very hard. They want you to bring an interpreter and- you know? – they're worse on the phone. They're really bad on the phone. Even if you ask them to speak a little slower. And I think that is our right – to have an interpreter – to be able to speak with someone e or have that someone speak to us."

Common Enrollment

Of the eight interviewees (5 government, 3 providers) who discussed common or unified enrollment, all supported some variation of the concept. The proposed models and their pros and cons as stated by the interviewees are summarized below:

1. Status quo, including pre-screening for Medicaid by Alliance enrollment workers

Pros

a. Avoidance of the "cons" listed under option #3.

Cons

a. Potential eligible may have to make two visits to two different sites, especially if family members qualify for different programs.
b. There is no incentive for Alliance to do the screening well; when the rolls of the two programs are compared, a large number of persons who are enrolled in both programs is uncovered.
c. Because Alliance workers are instructed to have people apply for Medicaid if they "appear" eligible, many people are unnecessarily applying for Medicaid, being denied, and then returning to complete the Alliance process. In the meantime, their access to medical services may be delayed.

2. Consolidated application process for Medicaid, Food Stamps, and TANF

Pros

a. This proposal would greatly simplify the application process for these programs. The proposed change requires a state plan amendment, which is likely to be approved by the city council and CMS.

3. Common enrollment for Medicaid and Alliance (with IMA assuming enrollment responsibilities)

Pros

a. Coordinated screening for these two programs (and others, such as Project WISH) would lead to more people enrolling in programs for which they qualify.
b. Duplicate payment of claims could be eliminated.
c. Alliance eligibles would have the chance to apply for Food Stamps through this single enrollment process. Similarly, when a person comes to an IMA enrollment site biannually to renew their Food Stamps, their Alliance recertification could be processed.
d. Clients would go to one site and complete only one form that combined eligibility requirements of both programs.
e. Savings could be realized by eliminating duplicative functions.
f. Community-based organizations could still be involved in enrollment; however, they would have to forward the applications to IMA for determination. IMA can also place enrollment workers in community-based organizations, as it does now.

Cons

a. Alliance operates with presumptive eligibility, while Medicaid uses retroactive payment. Although both programs could maintain their separate approaches under common enrollment, it would be simpler if both used retroactive payment.
b. The concern about eliminating presumptive eligibility is that providers may be hesitant to provide services if they are unsure they will get paid (retroactive payment is helpful only if the person is eventually enrolled, whereas presumptive eligibility leads to payment even if the person never enrolls). It was suggested that IMA would have the ability to expedite an application and grant eligibility on the date of enrollment if a patient needed a prescription drug or to see a specialist immediately.
c. Commingling of information presents a problem, as Alliance is not HIPAA compliant but Medicaid is.
d. Medicaid administrative costs are matched 50% by the federal government; there would be some accounting challenges regarding Alliance administration.
e. Medicaid does asset tests and spend-down, while Alliance does not.
f. Medicaid has a legal requirement that only its employees may determine eligibility; thus, community-based organizations (primary enrollment sites) that currently enroll patients in Alliance could assist in the completion of the applications but could not grant eligibility (i.e., assign a number). There is concern that community-based organizations, which have proven effective in enrolling clients, would no longer be utilized in outreach and enrollment.

4. Administration of the entire Alliance transferred to IMA and MAA.

(Pros and Cons also include those listed in proposal #3 above.)

Pros

a. Savings in administrative overhead would be more significant than those of proposal #3.
b. Providers would be paid on a more timely basis, as MAA is required to pay within 45 days
c. IMA has proven successful with enrollment.
d. Patients would be given a choice of HMOs and within that context educated about their choice of providers. Alliance enrollees seem less aware than Medicaid enrollees that they can switch providers.
e. Moving Alliance members into HMOs would allow for disease management.

Cons

a. Alliance might lose its unique partnership with providers, in which there is an opportunity to focus on health outcomes. The program would become a "payer," liked Medicaid.

5. Common enrollment for Medicaid, Alliance, and Mental Health

Pros

a. In general, more coordination is needed among mental health and other health services. Many persons with a mental health diagnosis have other health problems, leading to early mortality.
b. Savings could be realized by consolidating enrollment for these programs. An enrollment worker could be trained to determine income eligibility as well as conduct a mental health screening, as Department of Mental Health staff do. (Currently, the Department of Mental Health has 24/7 enrollment by telephone, staffed by four to five people during the day, two to three in the evening, and one at night. They also enroll persons face-to-face at community sites.)
c. In conjunction with common enrollment, providers should have the ability to determine from a secure web site the program(s) in which the patient is enrolled. Of particular interest to hospitals is the ability to track patients who have a substance abuse problem and move from ER to ER in search of drugs.

Cons

a. Eligibility for Medicaid/TANF/Food Stamps and Alliance are determined by income; mental health benefits have a clinical determination component.